TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-1955-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the TDI DWC fee schedule . . . this account qualifies for an Outlier payment"

Amount in Dispute: $1,960.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual believes no additional payment is due as an outlier payment beyond the paid amount of $3,883.15."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8, 2016	Outpatient Hospital Services	$1,960.83	$1,804.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – [a description of this code was not found with the submitted materials]
   - 350 – [a description of this code was not found with the submitted materials]
   - 356 – THIS OUTPATIENT ALLOWANCE WAS A BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 724 – [a description of this code was not found with the submitted materials]
   - 767 – PAID PER 9O/P FG AT 200%; IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TREATMENT MEDICAL FEE GUIDELINE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - W3 – [a description of this code was not found with the submitted materials]

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

2. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code J7120 has status indicator N denoting packaged codes with no separate payment that are integral to the total service package; reimbursement is included in the payment for the primary services.
   - Procedure codes 36415, 80048, 82550, 82565, 85025, and 85610, have status indicator Q4 denoting packaged lab services. Payment is included in the reimbursement for the primary service(s).
   - Procedure code 71010 has status indicator S denoting significant OPPS procedure with separate APC payment, not subject to multiple-procedure reduction. This is classified under APC 5521, which, per OPPS Addendum A, has a payment rate of $60.80. This amount multiplied by 60% yields an unadjusted labor-related amount of $36.48, which is multiplied by the facility's annual wage index of 0.9572 for an adjusted labor-related amount of $34.92. The non-labor portion is 40% of the APC rate or $24.32. The sum of the labor and non-labor portions is $59.24. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement for this line is $59.24. This amount multiplied by 200% yields a MAR of $118.48.
   - Procedure code 72170, 73130, and 73552 have status indicator Q1 denoting STVX-packaged codes; payment is packaged with the reimbursement for any other procedures with status indicator S, T, V, or X billed on the same claim. This code is separately payable only if no other such procedures are billed the same day.

- Per Medicare policy, procedure code 96374 may not be reported with procedure code 73706 billed on this same claim. Reimbursement for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate the services. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment cannot be recommended.
- Procedure codes 72125, 73706, 74177, 70450, and 71260 have status indicator Q3 denoting packaged codes paid through a composite APC. Services assigned to a composite APC are major components of a single episode of care; the hospital receives one payment under a composite APC for multiple separate major services. Payment for any combination of designated procedures performed the same day is packaged into a single payment. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT and a "with contrast" CT are billed together, APC 8006 is assigned rather than APC 8005. If a composite includes multiple line items, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the bill. This line is assigned status indicator S denoting significant OPPS procedures with separate APC payment, not subject to multiple-procedure reduction. Per OPPS Addendum A, APC 8006 has a payment rate of $493.91. This amount multiplied by 60% yields an unadjusted labor-related amount of $296.35, which is multiplied by the facility's annual wage index of 0.9572 for an adjusted labor amount of $283.67. The non-labor portion is 40% of the APC rate or $197.56. The sum of the labor and non-labor portions is $481.23. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $3,250, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.194. This ratio is multiplied by the billed charge of $18,811, yielding a cost of $3,649.33. The total cost of packaged items is allocated proportionately across all separately paid OPPS services based on percentage of total APC payment. The APC payment for these services is $481.23, divided by the sum of all APC payments is 47.46%. The sum of packaged costs is $1,796.98. The allocated portion of packaged costs is $852.80. This amount added to the service cost yields a total cost of $4,502.13. The cost of these services exceeds the annual fixed-dollar threshold of $3,250. The amount by which the cost exceeds 1.75 times the OPPS payment is $3,659.98. 50% of this amount is $1,829.99. The Medicare facility specific reimbursement (including outlier payment) of $2,311.22 is multiplied by 200% for a MAR of $4,622.44.
- Procedure codes 96376, J2270, and Q9967 have status indicator N denoting packaged codes with no separate payment that are integral to the total service package; reimbursement is included in the payment for the primary services.
- Procedure code 99285 has status indicator J2 denoting hospital, clinic or emergency room visits (including observation and critical care services). This is classified under APC 5025, which, per OPPS Addendum A, has a payment rate of $486.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $291.62, which is multiplied by the facility's annual wage index of 0.9572 for an adjusted labor-related amount of $279.14. The non-labor related portion is 40% of the APC rate or $194.42. The sum of the labor and non-labor portions is $473.56. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement for this line is $473.56, which is multiplied by 200% for a MAR of $947.12.

3. The total allowable reimbursement for the services in dispute is $5,688.04. This amount less the total previously paid by the insurance carrier of $3,883.15, leaves an amount due to the requestor of $1,804.89. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,804.89.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,804.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.